# Crawford A. Tatum, Jr., D.M.D.
# Christina H. Cox, D.M.D.

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Opelika, Alabama 36801
334-745-6393
www.tatumandcoxdental.com


## Patient Information (CONFIDENTIAL)

Patient _____ Date _____

SS# _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov _____ Zip/PC _____

Cell Phone _____ Email _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____

Home Phone _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ❑ Yes ❑ No

## Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov _____ Zip/PC _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY SECONDARY INSURANCE? ❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov _____ Zip/PC _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

# Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ❑ | ❑ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | ❑ | ❑ |
| If yes, please explain _____ | | |
| 3. Do you use controlled substances? | ❑ | ❑ |
| 4. Have you ever taken Fen-Phen/Redux? | ❑ | ❑ |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | ❑ | ❑ |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | ❑ | ❑ |
| 7. Do you use tobacco? | ❑ | ❑ |
| 8. Are you taking any medication(s) including non-prescription Medicine? | ❑ | ❑ |
| If yes, what medication(s) are you taking? _____ | | |

| | Yes | No |
|---|---|---|
| 11. Are you allergic to or have you had any reactions to the following? | | |
| Local Anesthetics (e.g. Novocain) | ❑ | ❑ |
| Penicillin or any other Antibiotics | ❑ | ❑ |
| If yes, what medication(s) are you taking? _____ | | |
| Sulfa Drugs | ❑ | ❑ |
| Barbiturates | ❑ | ❑ |
| Sedatives | ❑ | ❑ |
| Iodine | ❑ | ❑ |
| Aspirin | ❑ | ❑ |
| Any Metals (e.g. nickel, mercury, etc.) | ❑ | ❑ |
| Latex Rubber | ❑ | ❑ |
| Other (please list) _____ | | |
| 12. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | ❑ | ❑ |
| b) Are you nursing? | ❑ | ❑ |
| c) Are you taking oral contraceptives? | ❑ | ❑ |

9. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ❑ | ❑ | Heart Disease | ❑ | ❑ | Stroke | ❑ | ❑ |
| Heart Attack | ❑ | ❑ | Cardiac Pacemaker | ❑ | ❑ | Hay Fever / Allergies | ❑ | ❑ |
| Rheumatic Fever | ❑ | ❑ | Heart Murmur | ❑ | ❑ | Tuberculosis | ❑ | ❑ |
| Swollen Ankles | ❑ | ❑ | Angina | ❑ | ❑ | Radiation Therapy | ❑ | ❑ |
| Fainting/Seizures | ❑ | ❑ | Emphysema | ❑ | ❑ | Glaucoma | ❑ | ❑ |
| Asthma | ❑ | ❑ | Cancer | ❑ | ❑ | Recent Weight Loss | ❑ | ❑ |
| Low Blood Pressure | ❑ | ❑ | Arthritis | ❑ | ❑ | Liver Disease | ❑ | ❑ |
| Epilepsy / Convulsions | ❑ | ❑ | Joint Replacement or Implant | ❑ | ❑ | Heart Trouble | ❑ | ❑ |
| Leukemia | ❑ | ❑ | Hepatitis / Jaundice | ❑ | ❑ | Respiratory Problems | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Sexually Transmitted Disease | ❑ | ❑ | Mitral Valve Prolapse | ❑ | ❑ |
| Kidney Diseases | ❑ | ❑ | Stomach Troubles / Ulcers | ❑ | ❑ | Other_____ | ❑ | ❑ |
| AIDS or HIV Infection | ❑ | ❑ | Chest Pains | ❑ | ❑ | | | |
| Thyroid Problem | ❑ | ❑ | Easily Winded | ❑ | ❑ | | | |

# Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ❑ | ❑ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ❑ | ❑ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ❑ | ❑ |
| 4. Do you feel pain to any of your teeth? | ❑ | ❑ |
| 5. Do you have any sores or lumps in or near your mouth? | ❑ | ❑ |
| 6. Have you had any head, neck or jaw injuries? | ❑ | ❑ |
| 7. Have you ever experiences any of the following problems in your jaw? | | |
| Clicking | ❑ | ❑ |
| Pain (joint, ear, side of face) | ❑ | ❑ |
| Difficulty in opening or closing | ❑ | ❑ |
| Difficulty in chewing | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ❑ | ❑ |
| 9. Do you clench or grind your teeth? | ❑ | ❑ |
| 10. Do you bite your lips or checks frequently? | ❑ | ❑ |
| 11. Have you ever had any difficult extractions in the past? | ❑ | ❑ |
| 12. Have you ever had any prolonged bleeding following extractions? | ❑ | ❑ |
| 13. Have you had any orthodontic treatment? | ❑ | ❑ |
| 14. Do you wear dentures or partials? | ❑ | ❑ |
| If yes, Date of placement _____ | | |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ❑ | ❑ |
| 16. Do you like your smile? | ❑ | ❑ |

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____

_____

_____

Signature _____ Date _____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement***

**I, _____have received a copy of this office's Notice of Privacy Practices.**

**Please Print Name _____**

**Signature_____Date_____**

## For Office Use Only

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

**❑ Individual refused to sign**

**❑ Communications barriers prohibited obtaining the acknowledgement**

**❑ An emergency situation prevented us from obtaining acknowledgement**

**❑ Other (Please Specify) _____**

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Section A: PATIENT GIVING CONSENT Name: _____**

**Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

**Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signed this Consent.**

**We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.**

**You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting:**

**Tatum and Cox**
**(334) 745-6393**
**www.tatumandcoxdental.com**

**Right to revoke: you will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.**

**SIGNATURE**

**I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

**Signature_____ Date_____**

**If this consent is signed by a personal representative on behalf of the patient, complete the following:**

**Personal Representative's name _____**

## HIPAA Acknowledgement

**I understand that I may inspect or copy the protected health information described by this authorization.**

**I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.**

**I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,**

**I understand the above information and agree with its contents.**

**Signature_____ Date_____**

# Written Financial Policy

Thanks you for choosing Crawford A. Tatum, Jr. & Christian H. Cox. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

## Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Crawford A. Tatum, Jr. & Christian H. Cox requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. [2]

Crawford A. Tatum, Jr. & Christian H. Cox charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature_____ Date_____

Patient Name (Please Print) _____

[1] Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of our treatment fees and collection of your benefits directly from your insurance carrier.

There are multiple insurance contracts, even within the same insurance company. Tatum and Cox cannot certify that every procedure will be covered by insurance. Tatum and Cox prefers to provide the best procedure for your diagnosis. The patient is responsible for payment for all procedures not covered by insurance. Once the insurance yearly limit is exceeded procedures may not be filed with your insurance company. Tatum and Cox will try and file the insurance such that the patient receives as much of the insurance coverage as possible.

If a recommended procedure incurs more cost to Tatum and Cox than the projected insurance payment will cover, then that procedure will not be filed with the insurance company and the patient is fully responsible. These procedures will be reviewed in advance of treatment.

Patient Signature _____ Date_____